INDIAN HEALTH SERVICE
RESOURCE AND PATIENT MANAGEMENT SYSTEM

Patient Information Management System (PIMS)

ADT Module
&
Sensitive Patient Tracking

Training Manual

May 2004

Information Technology Support Center
Division of Information Resources
Albuquerque, New Mexico

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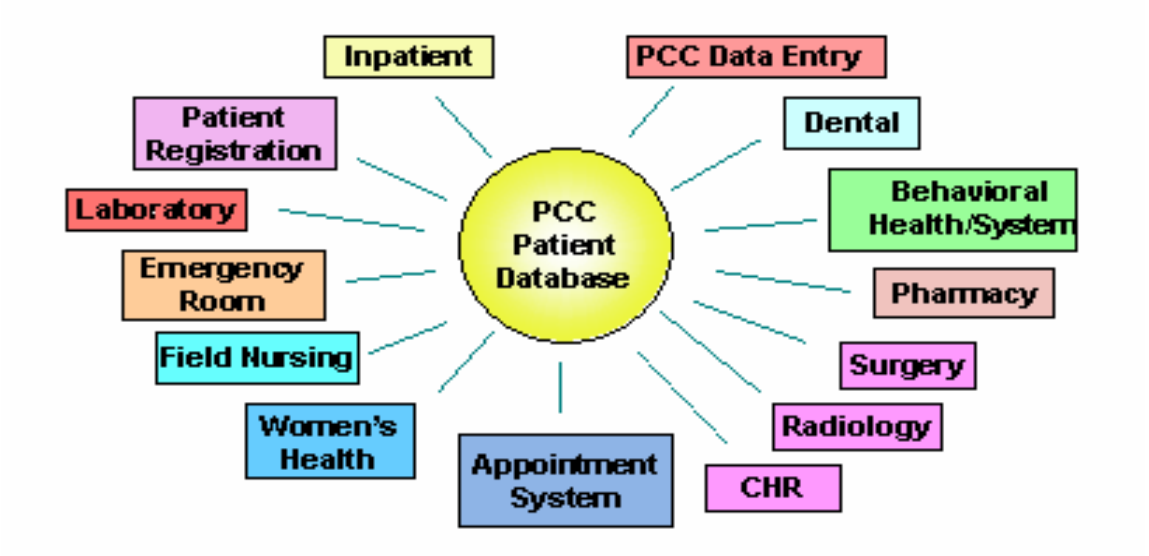
INTRODUCTION TO RPMS AND PIMS V5.3

Resource and Patient Management System (RPMS) is an integrated solution for management of clinical and administrative information in healthcare facilities of various sizes and orientation. RPMS is a decentralized automated information system of over 50 integrated software applications. Many RPMS applications can function in a stand-alone environment if necessary or appropriate. The system is designed to operate on micro- and mini-computers located in IHS or tribal healthcare facilities.

The Scheduling, ADT, and Day Surgery modules of PIMS interface with PCC to create visits in PCC as the applications are used. The service category of the PCC visit will reflect the PIMS module that is being used. These service categories are: ambulatory for outpatient scheduled visits, hospitalization for inpatient admissions, day surgery for day surgery visits, and observation for observation admissions.



Security

PIMS v5.3 requires you to have an RPMS access and verify code. A session will terminate when the your computer logs out or has no activity for ten minutes. No patient data is stored on your computer. When a session is completed, all data is erased from cache (memory).

Role-based access: You have access to options depending on their function (role). This allows the site manager to create a custom menu for each user by assigning security keys to each option.

Why would a site use PIMS v5.3?

- Allows sites to manage outpatient appointments in one centralized option
- Displays the appointment list. This list can include who made the appointment, primary care provider, phone number

- Offers new Primary Care Provider menu to assign primary care providers and teams to patients
- Can admit patients to Observation beds which will be included on the census
- New UB-92 admission types
- Day Surgery module that interfaces with PCC and Incomplete Chart list
- New IHS Sensitive Patient Tracking Module
- Alerts the appropriate staff that a user has accessed a restricted record

PIMS v5.3 Features

- Redesigned menus –"One-Stop Shopping"
- Centralized appointment menus-combines check-in, walk-in, cancel, no-show, etc
- Month-at-a-glance can handle 16-hour days
- Customizable Appointment Lists:-can sort by who made appt, phone #, primary care provider
- Can view appointment details from browse screen
- Chart Locator tool
- Can admit observation patients
- Observation patients included in patient lists, census, and statistical reports
- New UB-92 admission type
- Re-design of Incomplete Chart Analysis
- Day Surgery module interfaced with PCC and Incomplete Chart file
- Tracking of "sensitive" patients

Workflow Assessment and Change

Implementing all features of PIMS v5.3 may change how you do business. It is recommended that you identify your current workflow and plan for any changes before using any new software.

Sites Should Think About…

- Convenient access to computers for staff in or near exam rooms, offices, and Patient Registration
- System Requirements (especially when using the Sensitive Patient Tracking module)

Process change will be required when using the Observation Beds option, the Day Surgery option, or the Sensitive Patient Tracking module.

INTRODUCTION TO THE APPLICATION

Patient Information Management System (PIMS) is the name given by the VA for a suite of software of which IHS uses the following: data dictionary for the VA Patient file, Admission/Discharge/Transfer (ADT) application, Clinic Scheduling application, and Sensitive Patient Tracking (SPT) module. In version 5.0 this suite was called Medical Administration Service (MAS). This release includes all of the VA routines and options even if not currently used by IHS.

Purpose

The purpose of this PIMS v5.3 training is to give you the skills and knowledge needed to use PIMS to manage outpatient appointments; admit, transfer, and discharge inpatient visits; and track patients with restricted records.

Goal

Upon completion of this course, you will able to use the Appointment Management option to schedule appointments, check-in appointments, cancel appointments, and mark appointments as a "no-show". You will also be able to print various reports, request charts, find available appointments, and view the appointment list. If the site is using the ADT module, you will be able to admit, transfer, and discharge regular as well as observation patients. You will learn how to setup and monitor "sensitive patients" using the Sensitive Patient Tracking module.

Objectives

- **Bed Control** – Admit, discharge, and transfer a patient.
- **Patient Inquiry:** View data about a patient's demographics, admissions, day surgeries, and future appointments.
- **Provider Inquiry:** View a provider's inpatients, day surgeries, and scheduled appointments.
- **Day Surgery:** Enter data into the Day Surgery module and print reports.
- **ADT Reports:** Print admission, discharge, inpatient, and bed availability reports
- **Incomplete Chart Analysis:** Enter and edit patient data related to incomplete charts
- **Census Reports Menu:** Print Monthly and Yearly Census Reports
- **Inpatient Chart Coding:** Option for coding inpatient visits.
- **System Definitions:** Report the daily census for a facility. Set up a facility's ADT system.

- **Sensitive Patient Tracking Module:** Setup parameters to track sensitive patients.

1.0 Objective #1: Bed Control

Admit, discharge, or transfer a patient.

Purpose

This objective shows how to admit, discharge, and transferring patient options.

Goals

Upon completion of this objective, you'll be able to:

- Admit a patient for inpatient status
- Admit a patient for observation status
- Discharge a patient from your facility
- Transfer a patient to another treating specialty
- Transfer a patient to another ward

1.1 Admit a patient

Use this option to admit a patient to your facility for inpatient or observation status.

1. Log on to the ADT module.
2. On the main menu, select the Bed Control (BC) option.
3. Type **ADM** at the "Select Bed Control Option:" prompt.
4. Enter the patient's name, IHS chart number, date of birth or social security number at the "Admit Patient:" prompt. The patient's current statistics will be displayed.
5. After viewing the patient's current statistics, type **C** (continue) or **M** (view more patient data) at the "Continue, More, or Quit" prompt.
6. Type the date the patient was admitted at the "Select Admission Date:" prompt. If a patient is currently being admitted, accept the default response (*NOW*). The current date and time will be recorded at the admission time.
7. Type **Y** (Yes) at the "Sure You Want to Add "*The Shown Date and Time*" as New Admissions Date?" prompt to verify the new admission date.
8. Type **YES** or **NO** at the "Does The Patient Wish To Be Excluded From The Hospital Directory?" prompt. If you type **YES**, the patient will not appear in

the hospital directory. If you type **NO**, you will appear in the hospital directory.

9. Enter the type of admission at the "Admission Type-UB92?" prompt. To see a list of admission types, type two question marks (**??**) at the prompt.

10. Enter the source of admission at the "Admission Source-UB92?" prompt. To see a list of admission sources, type two question marks (**??**) at the prompt.

11. Enter the type of admission for the patient. To see a list of admissions, type two question marks (**??**) at the prompt.

12. Enter a description of the diagnosis associated with this admission at the "Diagnosis:" prompt.

13. Enter the ward on which the patient was placed at the "Ward Location:" prompt.

14. Enter the room and bed to which the patient was assigned at the "Room-Bed:" prompt.

15. Enter a selection from the Facility Treating Specialty file which best describes the care this patient is receiving at the "Facility Treating Specialty:" prompt. When entering a patient for observation, remember to select the observation entry for the Facility Treating Specialty.

16. Enter the provider referring the patient at the "Referring Provider:" prompt.

17. Enter the provider admitting the patient at the "Admitting Provider:" prompt.

18. Enter the attending physician for patient at the "Attending Physician:" prompt.

19. Enter comments concerning the admission at the "Additional Comments:" prompt.

20. Enter the condition of the patient at the "Condition:" prompt. To see a list of condition options, type two question marks (**??**) at the prompt. The visit for the hospital admission is now created.

NOTE: This question will only be asked if the ward is setup to be on the "Seriously Ill List".

21. The system will then automatically prompt for the printing of the A sheet. Type **YES** or **NO** at the "Print Bottom Half of A Sheet:" prompt. If you do not want to print an A sheet, type a caret (**^**) to bypass the option.

22. Type the number of copies of the report you need at the "Print How Many Copies:" prompt.

23. An A sheet will print. Press **Enter** to scroll through the report

24. Enter the Clinic name where the new admission's chart is to be sent at the "Clinic Name:" prompt.

25. Enter the location where the patient's charts are to be delivered at the "Deliver Charts To:" prompt. Automated updates are made concluding the patient's admission

Exercises

A. Your patient has come to the Emergency Room with a broken tibia that will require surgery to repair. Admit your patient to the south ward using the Surgery treating specialty.

B. Your other patient comes to the Emergency Room complaining of chest pains. Admit this patient for observation to the west ward using the Internal Medicine Observation treating specialty.

1.2 Transfer a Patient

Patients can be transferred to a different treating specialty or to a different ward.

1.2.1 Treating Specialty Transfer (TTX)

Use this option to enter a specialty change (e.g., General Medicine, Newborn, Obstetrics, Pediatrics, or Surgery) for an inpatient. Select the option that best describes the care an inpatient is receiving. For example, a patient's treating specialty.

1. Type **TTX** at the "Select Bed Control Option:" prompt.

2. Type the name of the inpatient for whom a specialty change will be entered at the "Specialty Change for Patient:" prompt. The inpatient's current status (date admitted, ward, provider, etc.) will be displayed.

3. Type **C** (to continue) or **M** (to view more data about the patient before continuing) at the "Continue, More, or Quit?" prompt.

4. Type the date the specialty change was entered at to the "Select Specialty Transfer Date:" prompt, or if a new specialty change is currently being entered for an inpatient, type **NOW** at to the "Select Specialty Transfer Date:" prompt and the current (today's) date and time will be recorded. To view a list of available options, type two question marks (**??**) at the "Select Specialty Transfer Date" prompt.

5. Type **Y** (Yes) at the "Sure You Want to Add (Date-Time) as a New Specialty Transfer Date?" prompt to verify the new specialty transfer date.

6. Type the new treating specialty assigned to the inpatient that best describes the care the inpatient is receiving at the "Facility Treating Specialty:" prompt. Type two question marks (**??**) to display a list of available options.

7. Type the name of the physician attending to this patient at the "Attending Physician:" prompt.

8. Type comments at the "Additional Comments:" prompt, or press **Enter** at the "Additional Comments:" prompt if there are no comments.

9. When the required specialty transfer changes are entered, "`Updating automated team lists…completed`" will be displayed on the screen.

Exercise

Your observation patient has suffered a heart attack. Transfer that person from the Internal Medicine Observation specialty to the regular Internal Medicine treating specialty .

1.2.2 Ward Transfer

Use this option to transfer a patient between wards. You will also be prompted with the "Treating Specialty Transfer Date:" prompt where you can transfer the patient's treating specialty and/or provider if either are changed at the time of transfer.

1. Type **WTX** at the "Select Bed Control Option:" prompt.

2. Type the name of the patient to be transferred at the "Transfer Patient:" prompt. The patient's current status will be displayed.

3. Type **C** (to continue) or **M** (to view more data about the patient before continuing) at the "Continue, More, or Quit?" prompt.

4. Type the date and time the patient will be transferred (or press the Return key to record the present as the transfer date and time) at the "Select Transfer Date:" prompt.

5. Type **Y** (Yes) at the "Sure You Want To Add "(Date/Time)" as a New Transfer Date?" prompt.

6. Type the information requested at the prompts that follow. To view a list of available options at any prompt, type two question marks (**??**) at the prompt to display a list of the available options.

7. When the transfer process is complete, `Patient Transferred` will be displayed.

Exercises

Transfer your cardiac patient from the West ward to the East ward and a new bed.

1.3 Discharge a Patient

Use this option to enter the date and time a patient is discharged as well as the type of discharge

1. Type **DSC** at the "Select Bed Control Option:" prompt.

2. Enter the patient's name, IHS chart number, date of birth or social security number at the "Discharge Patient:" prompt. The patient's current statistics will be displayed.

3. Type **C** (to continue) or **M** (to view more data about the patient before continuing) at the "Continue, More, or Quit?" prompt.

4. Type the date the patient was discharged at the "Discharge Date?" prompt. If a patient is currently being discharged, press **ENTER** or type **NOW** at the "Discharge Date?" prompt.

5. Type the discharge type at the "Type of Discharge?" prompt. To see a list of different types of discharges, type two question marks (**??**) at the prompt.

6. When the discharge process is complete, "Patient Discharged" will be displayed.

Exercise

Discharge your patient who suffered the broken tibia. It is a regular discharge to home.

2.0 Objective #2: ADT Reports

Print reports to obtain information on admissions and discharges, inpatient listings, , bed availability.

Purpose

This objective shows you how to print reports using the ADT Reports menu option. ADT reports have been grouped by type and placed on a condensed menu to make reports easier to find. All reports listing current inpatients can be found under the Current Inpatient listings, and reports listed by date are grouped under the Inpatient Listings by Date option.

Goals

Upon completion of this objective, you'll be able to print the following reports:

- Bed Availability
- Current Inpatient Census
- Current Inpatient Listing
- Admissions
- Discharges

2.1 Bed Availability

Use this option to view a list of empty beds by ward. The abbreviated view can optionally include bed descriptions. The expanded view can include scheduled admissions for the next 2 weeks, lodgers occupying beds on the ward as well as bed descriptions. Any bed with an asterisk (*) can be used by multiple wards. These can include OR and RR beds.

1. Log on to ADT module.
2. On the main menu, select the ADT Reports Menu (RM) option.
3. Type **BED** at the "Select ADT Reports Menu Option:" prompt.
4. Type **A** (Abbreviated) or **E (**Expanded) to view bed availability at the "(A)bbreviated or (E)xpanded Bed Availability Listing?" prompt.

2.1.1 Abbreviated Listing

Use this option to view bed availability for a single ward on your screen.

1. Type **A** (Abbreviated) at the "(A)bbreviated or (E)xpanded Bed Availability Listing? prompt.

2. Type the name of the ward at the "Select Ward Location Name:" prompt. Type two question marks (**??**) to see a list of the wards.

3. Type **YES** or **NO** at the "Do you want to display room-bed descriptions?" prompt.

4. The bed availability for the ward you selected will be displayed.

Exercise

Display an abbreviated bed availability listing for a ward of your choice on your computer screen.

2.1.2 Expanded Listing

Use this option to view bed availability for multiple wards.

1. Type **E** (Expanded) at the "(A)bbreviated or (E)xpanded Bed Availability Listing?" prompt.

2. Enter the Division(s) at the "Select Division:" prompt.

3. Type the name of the Ward at the "Select Ward:" prompt. After pressing Enter you will be prompted to enter the name of another ward. You can enter the name of another ward or just press **Enter** to continue processing the request.

4. Type **Yes** or **No** at the "Do you want to display scheduled admissions?" prompt.

5. Type **Yes** or **No** at the "Do you want to display lodgers?" prompt.

6. Type **Yes** or **No** at the "Do you want to display room-bed descriptions?" prompt.

7. Type the name of the print device at the "Device:" prompt or type **HOME** to display the report on your screen.

Exercise

Display an expanded bed availability listing for all wards on your computer screen.

2.2 Current Inpatient Census

Use this option to view the current number of inpatients and observation patients admitted to your facility. The report breaks down the counts by ward and by service.

1. Log on to ADT module.
2. On the main menu, select the ADT Reports Menu (RM) option.
3. Type **CIC** at the "Select ADT Reports Menu Option:" prompt.
4. Type **P** (print on paper) or **B** (browse on the screen) at the "Print Mode:" prompt.

Exercise

Display the current number of inpatient and observation patients admitted to your facility.

2.3 Current Inpatient Listing

Use this option to print different types of inpatient reports.

1. Log on to ADT module.
2. On the ADT module's main menu, select the ADT Reports Menu (RM) option.
3. Type **CIL** at the "Select ADT Reports Menu Option:" prompt.

2.3.1 Alphabetical Listing

Use this report to print an alphabetical listing of current inpatients at a facility.

1. Type **1** at the "Choose Report from List: (1-10)" prompt.
2. Type **P** (print on paper) or **B** (browse on the screen) at the "Print Mode:" prompt.

Exercise

Print an alphabetical listing of current inpatients at your facility. Print this listing to your computer screen.

2.3.2 List by Ward and Patient

Use this option to print an alphabetical listing of current inpatients by ward at a facility.

1. Type **2** at the "Choose Report from List: (1-10)" prompt.
2. Type **Y** or **N** at the "Print for All Wards:" prompt. If you select N, you will be prompted to enter the individual ward name.
3. Type **Y** or **N** at the "Would you like the Report Double Spaced?" prompt.
4. Type **P** (print on paper) or **B** (browse on the screen) at the "Print Mode:" prompt.

Exercise

Print an alphabetical listing of patients by ward for your facility. Print this listing to your computer screen.

2.3.3 List by Ward and Room

Use this option to print an inpatient list sorted by ward.

1. Type **3** at the "Choose Report from List: (1-10)" prompt.
2. Type **Y** or **N** at the "Print for All Wards:" prompt. If you type **N**, you will be prompted to enter the individual ward name.
3. Type the number of the data option you would like to include in the last column of your report at the "Select Last Column Data:" prompt.
4. Type **P** (print on paper) or **B** (browse on the screen) at the "Print Mode:" prompt.

Exercise

Print a listing of inpatients by ward, room, and bed for your facility. Print this listing to your computer screen.

2.4 Patient Admissions

Use this report to list patient admissions (inpatient and observations) for a given date range.

1. Enter **ILD** at the "Select ADT Reports Menu Option:" prompt.
2. Type **1** at the "Choose Report from List: (1-9)" prompt.
3. Type the starting date at the "Select Beginning Date:" prompt.
4. Type the ending date at the "Select Ending Date:" prompt.
5. Type the number of the type of admission report you would like to run at the "Select Admission Report to Run:" prompt. Each report will prompt you for different information.
6. Type **Y** or **N** at the "Insurance Coverage on Report?" prompt.
7. Type **P** (print on paper) or **B** (browse on the screen) at the "Print Mode:" prompt.

Exercise

Run a patient admissions report and display it on your computer screen. The beginning date is April 1, 2004. The ending date is today.

2.5 Patient Discharges

Use this report to list patient discharges (inpatient and observations) for a given date range.

1. Enter **ILD** at the "Select ADT Reports Menu Option:" prompt.
2. Type **5** at the "Choose Report from List: (1-9)" prompt.
3. Type the starting date at the "Select Beginning Date:" prompt.
4. Type the ending date at the "Select Ending Date:" prompt.
5. Type the number of the type of discharge report you would like to run at the "Select Discharge Report to Run:" prompt. Each report will prompt you for different information.
6. Type **Y** or **N** at the "Insurance Coverage on Report?" prompt.
7. Type **P** (print on paper) or **B** (browse on the screen) at the "Print Mode:" prompt.

Exercise

Run a patient discharges report and display it on your computer screen. The beginning date is April 1, 2004. The ending date is today.

3.0 Objective #3: Patient Inquiry

View data about a patient including demographics, admissions, day surgeries, scheduled appointments.

Purpose

This objective teaches you how to view data about a patient including demographics, admissions, day surgeries, scheduled appointments. For each section with data, you can expand it for more details.

Goal

Upon completion of this objective, you'll be able to:

- View data about a patient's demographic, admissions and future appointments.
- Expand the view of the demographic, admission, and future appointments for more details

3.1 Patient Inquiry

1. Log on to the ADT module
2. On the ADT main menu, select Patient Inquiry (PI)
3. Enter the patient's name. Review the information on the screen.
4. Select **X** for an expanded view of the data. Select **1** to view the demographic data. Select **Q** to quit (exit from the screen).
5. Select **X** for an expanded view of the data. Select **2** to view the admission data. If there is more than one admission date, choose the one that you are interested in. Select **Q** to quit (exit from the screen).
6. Select **X** for an expanded view of the data. Select **4** to view future appointment data. Select **Q** to quit (exit from the screen).

Exercises

A. Use Patient Inquiry to view data about your patient.

B. Expand the view of the demographic data.

C. Expand the view of the admission data.

D. Expand the view of the future appointments.

4.0 Objective # 4: Provider inquiry

This option is designed to be used by physicians to view current inpatients, today's surgeries and appointments. An expanded view of each patient encounter is also available.

Overview

A provider may use this option to view his inpatients, day surgery patients, and patients with appointments. Each type of encounter may be expanded for more details.

Goals

Upon completion of this objective, you'll be able to:

- View a provider's inpatients, day surgery patients, and patients with outpatient appointments.

4.1 Provider Inquiry

1. Log on to the ADT module
2. On the ADT main menu, select the Provider Inquiry (PV) option
3. Type the name of the provider. Select the type of sort (ward or service).
4. Review the provider's admissions, day surgeries, and future appointments.
5. Select **X** to expand the view and select one of the admissions to view. Select **Q** to quit (exit from the screen).
6. Select **X** to expand the view and select one of the day surgeries to view. After reviewing, select **Q** to quit (exit from the screen).
7. Select **X** to expand the view and select one of the appointments to view. After reviewing, select **Q** to quit (exit from the screen).

Exercise

Using Provider Inquiry, review your provider's admissions, day surgeries, and future appointments. Expand the view of one of each type of encounters.

5.0 Objective #5: Day Surgery Menu

Use this menu to track patients in an Outpatient Surgery program.

Purpose:

The purpose of this objective is to teach you how to use the Day Surgery module to track patients having outpatient surgery. The DS module can be used to record basic information on a day surgery visit. This module can track patients who stayed overnight for observation, patients admitted directly from day surgery, no-shows, and canceled surgeries.

Goals

Upon completion of this objective, you'll be able to:

- Enter a patient into the Day Surgery module
- Edit a past Day Surgery
- Print Patient List by Day Surgery Date
- Print List of Patients not Released
- Understand the link between DS, PCC, and the Incomplete Chart module

5.1 Add a Day Surgery Patient

1. Log on to the ADT module
2. On the ADT main menu, select the Day Surgery menu (DS)
3. On the Day Surgery menu, select the Day Surgery Enter/Edit option (DSE).
4. Type the name of the patient. Type **Y** at the "Are you adding this patient as a new Day Surgery?" prompt.
5. Information on the patient's inpatient status and future outpatient appointments will be displayed.
6. Enter the date/time of the Day Surgery and answer **Y** to "Are you adding this as a new Day Surgery date and time?".
7. Enter the procedure. This is a required field and is free text (3-30 characters).
8. Enter the diagnosis. This is required field and is free text (3-30 characters).

9. Enter the date/time to observation if the patient was sent to observation after surgery. If not, enter past this field.

10. If the patient was sent to observation, enter the required admission information at each prompt (ward location, room-bed).

11. Enter the treating specialty. This is a required field.

12. Enter the provider

13. Enter the release date/time. An entry in the incomplete chart file will not be created until the patient is released.

14. View your patient's visit in PCC (use the option Display Data for a Specific Visit). Notice that the service category is Day Surgery.

Exercise

Your patient has arrived for their outpatient surgery. Enter them into the Day Surgery module. If your patient went to observation, enter that information. Release your patient from Day surgery.

5.2 Edit a Past Day Surgery

1. On the Day Surgery menu, select the Edit Past Day Surgeries (DSP) option.

2. Enter the name of the patient whose past day surgery needs to be edited. The patient's data will be displayed.

3. Enter the date/time of the day surgery to be edited. Enter a question mark (**?**) to display past surgeries.

4. To edit the entry, type the change at the default prompt.

5. Press **Enter** past the fields that do not need to be changed.

Exercise

You need to correct the Day Surgery entry that you just created because you entered the incorrect procedure and diagnosis.

5.3 Print List of Patients by Day Surgery Date

1. On the Day Surgery menu, select the Patient List by Day Surgery Date (DSL) option.

2. Enter the date to start your search. Enter the date to go to. Enter you device for printing (use HOME for this exercise).

3. Review the list of Day Surgery patients

Exercise

The supervisor of the surgery department needs to know who had Day Surgery during the month of May.

5.4 Print List of Patients not Released

1. On the Day Surgery menu, select the List of Patients Not Released (DSNR) option.

2. Enter the beginning and ending dates for your search.

3. Enter your device for printing (use HOME for this exercise).

NOTE: Day Surgery patients that are not released will not have an incomplete chart created.

Exercise

At the end of each week, the surgery supervisor reviews the List of patients not released and releases any that are not completed. Print the list of Patients not Released for the previous week.

6.0 Objective #6: Incomplete Chart Analysis

Use this menu to enter and edit patient data related to incomplete charts. Reports can also be printed related to incomplete and coded charts

Overview

Use this option to record and/or edit patient data (e.g. clinical data, death information, incomplete chart, day surgery incomplete chart, and chart deficiencies). Also use this option to print various reports (e.g. Final A Sheets, Daily Discharges, Listing of Coded A Sheets).

Goal

Upon completion of this objective, you'll be able to:

- Update all incomplete charts for inpatient, observation, and day surgery patients.
- Track deficiencies by provider and completion dates for different phases of the incomplete chart process.
- Run various reports based on the incomplete chart file
- Use the on-line help for Incomplete Chart Reports
- Access reports giving statistics on current and past incomplete/delinquent charts

6.1 Incomplete Chart Edits (ICE)

Use this option to track an edit all inpatient, observation, and day surgery charts for discharged patients. Chart deficiencies can also be added by provider.

1. Log on to the ADT module
2. On the main ADT menu, select IC.
3. Select Incomplete Chart Edits (ICE).
4. Type the name of your patient. If your patient has more that one incomplete chart, these will be displayed. Select the incomplete chart entry that you are working on.
5. The Incomplete Chart Edit screen will be displayed. Use the tab or arrow keys to move between fields for entering data. You can type two question marks (**??**) at any prompt for information on entering the data.

6. When you are done entering the data, use the options at the bottom of the screen to save, go to next page, or exit.

> **Note:** Entries in the Incomplete Chart file are automatically created when an inpatient is discharged or a day surgery patient is released.

Exercise

A. Your patient with the broken tibia has been discharged and the medical record returned to the department. You are reviewing the chart for deficiencies and entering your findings into the Incomplete Chart file. Update the Incomplete Chart entry with several deficiencies for the attending provider.

B. The attending provider has completed the necessary chart deficiencies. Use ICE to complete the chart.

6.2 Discharges by Date

This report is a simple list of all discharges for a specific date range. The list is drawn from the Incomplete Chart file.

1. Log on to the ADT module
2. On the main ADT menu, select IC, and then Incomplete Chart Reports (ICR)
3. Select the option Discharges by Date
4. Enter the beginning date for the report and the ending report. Enter the device for printing.

Exercise

You would like to compare the number of discharges in the Incomplete Chart file to the number in the ADT reports option for the month of May. Print the Discharges by Date report in the ICR menu for the month of May.

6.3 Incomplete Charts by Provider

Use this report to list incomplete charts by provider. This report can be run for all providers, for those within select hospital services, or for those within select classes or name.

1. Log onto the ADT module
2. On the main ADT menu, select IC and then ICR

3. Select the option Incomplete Charts by Provider
4. Enter the type of visit you want included in your report
5. Type **Y** or **N** at the "Print report for All Providers?" prompt
6. Select the criteria that you want to include on your report
7. Enter the device for printing

Exercise

You are notifying all of your providers of the incomplete charts that they have for all inpatients and day surgery patients. Print the Incomplete Charts by Provider report for all providers for both inpatients and day surgeries.

6.4 On-line Help (Report Descriptions)

Use this option to display detailed report descriptions of all reports in the incomplete report submenu.

1. Log on to the ADT module
2. On the main ADT menu, select IC, then ICR
3. Select the option On-line Help (Report Descriptions)
4. Type the number of the report for which you need a description.

Exercise

You are looking for a report listing how many incomplete charts a particular provider has. Use the On-line help and read the description of the Incomplete Chart reports.

6.5 Inpatient Coding Status Report

Use this report as a replacement of the ASR-Coding Status of A sheets report from MAS. For the months selected, this report will count the number of discharges, number coded, number not coded, number exported, and number of errors.

1. Log onto the ADT module
2. On the main ADT menu, select IC and then Incomplete Chart Statistics (ICS)
3. Select the option Inpatient Coding Status Report (#1)

4. Enter the beginning and ending month for your report. Select the device for printing.

Exercise

It is the end of the month and you want to print the Inpatient Coding Status Report for May 2004

6.6 Workload Report (Completion Times)

Use this report to show how long each stage in the completion process takes. The report can be for either inpatients or day surgeries and sorted alphabetically or by terminal digit.

1. Log on to the ADT module
2. On the main ADT menu, select IC, then Incomplete Chart Statistics (ICS)
3. Select the option Workload Report (Completion Times) (#3)
4. Select either Inpatients or Day Surgeries
5. Enter the beginning and ending discharge dates
6. Select your sort, either alphabetically or by terminal digit
7. Select the device for printing. This should be a printer with wide paper or condensed print.

Exercise

It is the end of the month and you want print the Workload Report to see how long it takes your staff to complete the inpatient charts. Print the Workload Report for May 2004 for inpatients.

7.0 Objective #7: Inpatient Chart Coding

This option is used to code inpatient visits. The actual coding is done in PCC to which this option links the user. Any data in common between ADT and PCC, if edited here, will be updated in both files.

Overview

Coding of inpatient visits is an integral part of the functions in the medical records department. Though the coding of the inpatient visit is done via the ADT module, the PCC files are also updated. You may also view all In Hospital Visits for the date range of the inpatient stay, run the PCC edit check and print a final A Sheet.

Goal

Upon completion of this objective, you'll be able to:

- Update admission data
- Add/modify PCC data related to the inpatient visit
- Update the problem list
- Print the final A sheet
- List all I visits (these are pcc visits created by other ambulatory services , e.g. lab or pharmacy, while the patient is an inpatient)

7.1 Inpatient Chart Coding (CODE)

1. Log on to the ADT module
2. On the main ADT menu, select IC, then select the option Inpatient Chart Coding (CODE)
3. Enter the patient's name and select the visit that you need to code (if there is more than one). The Code Inpatient Visits screen will be displayed.
4. Select **1** to update the admission data. Type responses to each of the prompts as they are displayed on your screen. At the "select patient" prompt, enter the next patient or press enter to return to the coding screen.
5. Select **2** to add or update PCC data. Type a number and add or modify existing information.

6. Select **3** to update the problem list. Enter the location where the problem occurred and use the options at the bottom of the screen to update the problem list.

7. Select **6** after the coding is complete to print the final A sheet. You may include the CPT codes or print a Medicare/Medicaid A sheet.

8. Select **4** to list all "I" visits. If one of these inpatient visits needs to be edited, choose "edit visit" and

Exercises

A. Using the CODE option, code your patient with the broken tibia inpatient visit. Enter the POV, Primary Provider, and update the Problem List. (NOTE: Your patient must be discharged before the coding can be done)

B. After the coding is complete, print the final A sheet to your screen.

C. List the I visits (lab or pharmacy visits while the patient was an inpatient).

8.0 Objective #8: Census Reports Menu (CEN)

This menu contains reports used by ADT supervisory staff to balance census files and report on them.

Overview

Inpatient facility must balance and report their inpatient census monthly. These reports provide various views of the census and can be used for reporting to the area offices or for internal use.

Goal

Upon completion of this objective, you'll be able to:

- Track census by Ward
- Print the M202 Monthly Report
- Print the Y202 Report for a Range of Dates

8.1 Track Census by Ward

Use this option to list an overview of the bed movements for a particular ward for a date range.

1. Type **SM** at the "Select ADT Menu Option:" prompt.
2. Type **CEN** at the "Select ADT Supervisor Menu Option:" prompt
3. Type **AID1** at the "Select Census Reports Menu Option:" prompt in the Census Reports menu.
4. Type the name of the ward to be printed at the "Select Ward:" prompt.
5. Type the beginning date for the census at the "Select Beginning Date:" prompt.
6. Type the ending date of the census at the "Select Ending Date:" prompt.
7. Type **P** (print on paper) or **B** (browse on the screen) at the "Print Mode:" prompt.

8.2 M 202 Monthly Report of Inpatient Services (HSA-202-1)

Use this option to print the HSA-202-1 form for reporting inpatient services at your facility for a specific month. Unlike most ADT reports, this report is designed to print only on paper so it is not available in list manager mode.

1. Log on to the ADT module.
2. On the main ADT menu, select the ADT Supervisors Menu (SM). Select the Census Reports Menu (CEN).
3. Select the M202 report. Enter the month for your report.
4. Enter the device for printing (use HOME for this exercise)

8.3 Y 202 HSA-202-1 Report by Range of Dates

Use this option to print a report in the HSA-202-1 format BUT for a range of months. This can be used to view your facility's inpatient services over time. Like the M202, this report is designed to print on paper.

1. Log on to the ADT module
2. On the main ADT menu, select the ADT Supervisors Menu (SM). Select the Census Reports Menu (CEN).
3. Select the Y 202 Report. Enter the beginning and ending months for the report.
4. Enter the device for printing (use HOME for this exercise). This report is in the same format as the M202, but for a range of dates.

Exercises

A. You need to print the census for the West ward for April and May.

B. You need to print the M 202 report for April 2004.

C. You need to print the Y 202 report for all of 2003.

9.0 Objective #9: System Definitions

Run selected Admission and Discharge reports and set up a facility's Admission/Discharge/Transfer system.

Purpose

This objective teaches you how to report the daily census for a facility, run an update to the census fields without printing A&D sheets, and setting up the ADT system for your facility.

Goal

Upon completion of this objective, you'll be able to:

- Report the daily census for a facility
- Update the census fields without reporting the daily census
- Set up the ADT system for your facility

9.1 Admission and Discharge Sheets

Use this option to report the daily census for a facility. The Admission and Discharges (A&D) sheet lists admission, discharges, and transfers.

1. Log on to the ADT module.
2. On the ADT System's main menu, select the ADT Supervisor Menu (SM) option.
3. Type **ADS** at the "Select Supervisor ADT menu Option:" prompt.
4. Type the day you want a report above at the "Print Report For Which Date:" prompt.
5. Type **YES** or **NO** at the "Recalculate Totals?" prompt to indicate if existing totals need to be recalculated.
6. Type **D** (Detailed) or **S** (Summary) to indicate the type of report to be printed.
7. Type a print device at the "Device:" prompt.

Exercise

Report yesterday's daily census for your facility.

9.2 Recalculate the Census (REC)

Use this option to run an update to the census fields without printing out any A&D sheets. This may be necessary if changes have been made to past admissions and the census does not appear to be correct.

1. Type **REC** at the "Select Supervisor ADT menu Option:" prompt.

2. Type the date from which you want totals recalculated at the "Recalculate Totals from which Date:" prompt. After pressing **ENTER**, the census totals will be recalculated.

Exercise

Recalculate the census totals for your facility from January 1, 2004.

9.3 System Definition Menu

Use this option to set up the ADT System in a way that best suits the facility.

1. Type **SYS** at the "Select Supervisor ADT menu Option:" prompt. The ADT System Definition menu will be displayed.

9.3.1 Check ADT-PCC Link (CKL)

Use this option to display the status of the link between ADT and PCC. The link must be turned on for data to be passed to PCC.

1. Type **CKL** at the "Select ADT System Definition Menu Option:" prompt.

2. The ADT-PCC Link Environment will be displayed.

Exercise

Display the status of the link between ADT and PCC on your computer screen.

9.3.2 Edit ADT Parameters (EAP)

Use this option to set up and maintain facility and system parameters dealing the ADT function in PIMS.

1. Type **EAP** at the "Select ADT System Definition Menu Option:" prompt.

9.3.2.1 Editing System-wide Parameters

Use this option to edit the Primary Facility Name and whether or not the facility is a Multidivisional Medical Center.

1. Type the name of the Primary Facility at the "Primary Facility Name:" prompt.

2. Type **YES** or **NO** depending if you facility is a multidivisional medical center at the "Multidivision Med Center:" prompt.

9.3.2.2 Editing Facility-wide Parameters

Use this option to edit the parameters within your facility. You will be able to edit several ADT parameters and default entries.

1. Type the division name or number where you will be making changes at the "Select IHS ADT Parameters Division:" prompt.

2. Type **YES** to confirm your selection at the "OK?" prompt.

3. Type the number or name of the facility where you want to set the file pointer at the "Institution File Pointer:" prompt.

4. Type the number of your facility at the "Facility Number:" prompt or press **ENTER** to accept the default entry. The will display the ADT Parameters screen. Use the tab or arrow keys for moving between fields.

5. Add or edit information requested at the prompts. When you're done, use the options at the bottom of the screen to exit, save, or go to the next page.

6. Continue typing answers for each of the fields for the different pages.

9.3.3 Initialize the Census Files (ICF)

Use this option ONLY when you need to start over with your census files.

1. To initialize census files, type **ICS** at the "Select ADT System Definition Menu Option:" prompt.

2. Type the minimum age for adult patients at the "Minimum Age for Adult Patients:" prompt or press **ENTER** to accept the default age.

3. Type the earliest date for G&L at the "Earliest Date for G&L:" prompt or press **ENTER** to accept the default date.

4. Type **YES** at the "Ready to Initialize Census for Oct, 01, 1995?" prompt to initialize the files. Type **NO** to escape this option.

9.3.4 List ADT Security Keys (KEY)

Use this option to view the active ADT keys.

1. To list the ADT security keys, type **KEY** at the "Select ADT System Definition Menu Option:" prompt in the ADT System Definition menu. The ADT Security Keys screen will be displayed.

9.3.5 Setup ADT Files (SAF)

Use this option to access the Setup ADT Files menu that will enable you to set up and modify local fields in the ADT standard files.

1. To access the Setup ADT Files menu, type **SAF** at the "Select ADT System Definition Menu Option:" prompt in the ADT System Definition menu. The SAF menu will be displayed

9.3.5.1 Hospital Service Setup

Use this option to add or edit a hospital service in your system.

1. Type **1** at the "Choose Setup Option:" prompt on the SAF menu.

2. On the Hospital Service Setup screen, type the number of the option Service you would like to add or edit at the "Select Action:" prompt.

3. Add or edit information requested at the prompts. When your done, use the options at the bottom of the screen to exit, save, or go to the next page.

9.3.5.2 Treating Specialty Setup

Use this option to edit the treating specialties for your facility.

1. Type **2** at the "Choose Setup Option:" prompt on the SAF menu.

2. To edit a treating specialty, type **1** at the "Select Action:" prompt, then type the number of the specialty at the "Select Treating Specialty:" prompt. To print the treating specialty list, type **2** at the "Select Treating Specialty:" prompt. If printing, type a print device at the "Device:" prompt.

3. Add or edit information requested at the prompts. When you are done, use the options at the bottom of the screen to exit, save, or go to the next page.

9.3.5.3 Ward Setup

Use this option to add or edit a ward at your facility.

1. Type **3** at the "Choose Setup Option:" prompt in the SAF menu.

9.3.5.3.1 Edit an Inpatient Ward

Use this option to edit an existing inpatient ward at your facility.

1. Type **2** at the "Select Action:" prompt.
2. Type the number of the ward you wish to edit at the "Select Ward:" prompt.
3. Add or edit information requested at the prompts. When your done, use the options at the bottom of the screen to exit, save, or go to the next page.

9.3.5.3.2 Add an Inpatient Ward

1. Use this option to add a new ward to your facility
2. Type **1** at the "Select Action:" prompt.
3. Type the name of the new ward at the "Select Ward Location Name:" prompt.
4. Type **YES** at the "Are you adding '(New Name)' as a new Ward Location?" prompt to confirm your selection.
5. Type the file pointer name at the "Ward Location Hospital Location File Pointer:" prompt.
6. Type the name of the division that this ward belongs to at the "Ward Location Division:" prompt.
7. Add or edit information requested at the prompts. When you're done, use the options at the bottom of the screen to exit, save, or go to the next page.

Exercise

Active a treating specialty to be used for admissions. The effective date should be 1/1/2003.

9.3.5.4 Room-Bed Setup

Use this option to add or edit a room or bed at your facility.

1. Type **4** at the "Choose Setup Option:" prompt in the SAF menu.

2. On the Room-Bed Setup screen, type 1 at the "Select Action:" prompt add a new entry. Add or edit information requested at the prompts. When you're done, use the options at the bottom of the screen to exit or save the screen.

Group Exercise

Add 2 rooms to the west ward. There will be two beds in each room.

9.3.5.5 Transfer Facilities Setup

Use this option to edit or add transfer facility parameters.

1. Type **5** at the "Choose Setup Option:" prompt in the SAF menu.

9.3.5.5.1 Add a New Facility

1. Use this option to add a new transfer facility
2. To add a new facility, type 1 at the "Select Action:" prompt.
3. Type the name of the new facility at the "Select Transfer Facility Name:" prompt.
4. Type **YES** at the "Are you adding (new facility name) as a new Transfer Facility:" prompt to confirm your selection.
5. Add or edit information requested at the prompts. When you're done, use the options at the bottom of the screen to exit or save the screen.

9.3.5.5.2 Edit a Facility

1. Use this option to edit a transfer facility
2. To edit an existing facility, type 2 at the "Select Action:" prompt.
3. Type the number of the facility you want to edit at the "Select Facility:" prompt.
4. Type the new name of the facility at the "Name:" prompt or press **ENTER** to keep the default setting.
5. If you are typing a facility as inactive, type the inactive date at the "Inactivation Date:" prompt or press **ENTER** to bypass this option.
6. Type the name of the facility that his transfer facility is linked with at the "Facility Link:" prompt or press **ENTER** to keep the default setting.

Exercise

Add the name of your facility at home as a transfer facility.

9.3.5.6 ADT Event Drive View

Use this option to view the ADT event driver.

1. Type **6** at the "Choose Setup Option:" prompt in the SAF menu.
2. The ADT Event driver will be displayed. Use the options at the bottom of the screen to navigate the screen.

9.3.5.7 Add Mail Groups to PIMS Bulletins

Use this option to add mail groups to the PIMS bulletins.

1. Type **7** at the "Choose Setup Option:" prompt in the SAF menu.
2. Type **1** at the "Select Action:" prompt.
3. Type the number of the bulletin name you wish to add at the "Select Bulletin:" prompt.
4. Type the name of the mail group you wish to add at the "Select Mail Group:" prompt.
5. Add or edit information requested at the prompts. When you're done, use the options at the bottom of the screen to exit or save the screen.

9.4 View A&D Corrections

Use this option to view any corrections in the Admissions and Discharges Sheet.

1. Type **VAD** at the "Select ADT Supervisor Menu Option:" prompt in the Supervisor ADT menu.
2. Type the G&L corrections date of change to be viewed was made at the "Select G&L Corrections Date of Change:" prompt. The changes made on that date will be displayed.

Exercise

View G&L corrections for March 8, 2004 on your computer screen.

10.0 Objective #10: Sensitive Patient Tracking

Sensitive Patient Tracking contains the security options for assigning, displaying, and purging information related to sensitive patient records. Only holders of the DG SECURITY OFFICER key have access to this menu.

Overview

As part of the effort to ensure patient privacy, additional security measures have been added to the patient access function. Any patient flagged as Sensitive will have access to his/her record tracked. In addition, warning messages will be displayed when staff (not holding special keys) accesses these records. If the person chooses to continue accessing the record, a bulletin is sent to a designated mail group

Goal

Upon completion of this objective, you'll be able to:

- Use the on-line tutorial for assistance with the module
- Update the Security Parameters for how your site will use SPT
- Assign security levels for your patients
- List Sensitive Patients
- Display user access to patient records
- Review warning messages that users will see when accessing sensitive patients

10.1 Sensitive Patient Tutorial

This option provides you with a detailed help menu for options in the Sensitive Patient Tracking module. You will be given the option to either display the help onscreen or print the information to paper.

1. Log on to the Sensitive Patient Tracking module.
2. On the Sensitive Patient Tracking main menu, select the option Sensitive Patient Tutorial (XSO).
3. Select "screen" to display the tutorial and pick each of the tutorials to review.

Exercise

You have decided to setup the Sensitive Patient Tracking module. Before you start, you want to review the tutorial.

10.2 Update Security Parameters

Use this option to update such parameters as "Days to Maintain Sensitivity" and "Restrict Patient Record Access". You can assign mail groups to bulletins and add members to the mail groups. A listing of all users with access to this menu and sensitive records is available. Log on to the Sensitive Patient Tracking module

1. Log on to the Sensitive Patient Tracking module.

2. On the main Sensitive Patient Tracking menu, select Update Security Parameters. Three options will be displayed.

3. Select Edit Security Parameters (#1) and answer the 5 questions depending on how you will use the module. Enter the name of the mail group that will receive the bulletins when a sensitive patient's record is accessed.

4. Save the parameters and exit from the screen.

5. Select Edit Mail Group Members (#2) and enter the name of the mail group that you created in the parameters. Enter the coordinator of the group, any description that is necessary, and the members of the group. These members will receive mailman bulletins when a sensitive patient's record is accessed. Save your changes and exit from the screen

6. Select List Security Key holders (#3). This option will display the users who have the important keys for this module.

Exercise

Review all of the Security Parameters for this site, keeping in mind how you will setup your site. DO NOT make any changes to the current parameters.

10.3 Enter/Edit Patient Security Level

For holders of the DG SENSITIVITY key, use this option to assign a security level to a patient. A patient can be either Sensitive (access tracked) or Non-Sensitive (access no longer tracked unless all patients tracked at facility). If the security level for a patient changes from sensitive to non-sensitive, a bulletin is sent to your site's mail group listed as "Sensitivity Removed Group" under the security parameters.

1. Log on to the Sensitive Patient Tracking Module

2. On the main SPT menu, select Enter/Edit Patient Security Level (EPL).

3. Enter the name of the patient that you want to designate as sensitive.

4. Change the security level to “sensitive” and enter the security source.

Exercise

Enter your 2 or your patients into the SPT module and designate them as “sensitive” with your own security source.

10.4 List Sensitive Patients

Use this option to list all patients marked as sensitive in the DG SECURITY LOG file. You can then change their security level or display who accessed each record. You cannot add new patients to the list here. Instead use the Enter/Edit option.

1. Log on to the Sensitive Patient Tracking module.

2. On the SPT main menu, select the option List Sensitive Patients (LSP).

3. Select *edit security level*, select one of your patients, and change the security level to non-sensitive.

4. Select *who accessed record* and select one of your patients. Enter the beginning and ending dates for review. Enter “no” to the question “Do you want to see a when a select user accessed this record?” to see all users accessed the record. View the report on your screen (HOME).

Exercise

You want to review who has been designated as sensitive and change one of them to non-sensitive. You also want to view who has accessed the record of one of your sensitive patients.

10.5 Display User Access to Patient Record

For holders of the DG SECURITY OFFICER key, use this option to display who accessed a particular patient record over a given date range. You can view just one user's access or that of all users who accessed the record. This is a view only option and can be used to view who has accessed any patient record (sensitive or not) if the site parameters are set to “Track All Patient Access”//YES

1. Log on to the Sensitive Patient Tracking module

2. On the main SPT menu, select Display User Access to Patient Record (DUA).

3. Enter the name of your patient, the beginning and ending dates for your review
4. Enter yes or no to whether you want to see when a select user accessed a record
5. Display the report on your screen.

Exercise

You are tracking access to all of your patient's records. You need to review one particular patient to see who has accessed their record during the past month. Use your patient, and review who has accessed their record.

10.6 View the warnings and mailman bulletins

Any patient flagged as "Sensitive" will have access to his/her record tracked. In addition, warning messages will be displayed when staff (not holding special keys) access these records. If the person chooses to continue accessing the record, a bulletin is sent to a designated mail group.

The long warning message is removed when accessing inpatients since those records must be accessed many times a day. A site can also restrict staff members from accessing their own patient record.

1. Set security parameter to track all patient's records.
2. Access your patient's record with any option (make an appointment, update patient registration, etc). Notice the warning message that you receive when the record is accessed
3. Remove the DG SENSITIVE key from the users and access your patient's record again. Notice the difference in warning that you receive.
4. Read the mailman bulletins you have received.

Exercise

You have finished setting up your SPT module and want to see if it is working properly. Access the record of one of your sensitive patients and review the warning that you receive. De-allocate the DG SENSITIVE key from yourself and access your patient's record again. Notice the difference in the bulletin that you receive. Review the mailman bulletins that you are receiving.

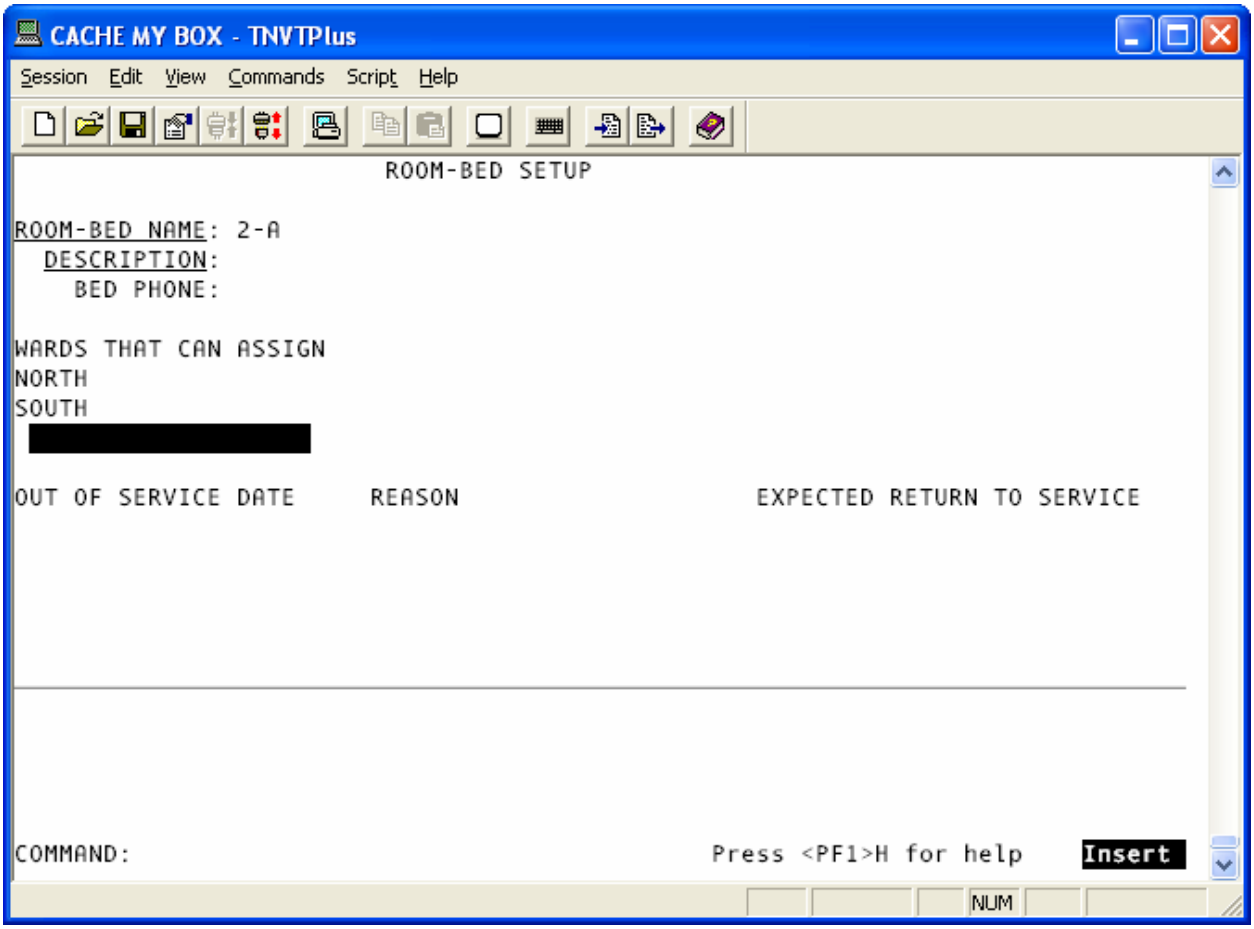
11.0 Appendix A: FAQ

1. **Question:** Why does bed 17A show up on the Room-Bed setup list, but when I try to admit a patient to that bed, I can't pick that bed?

   Answer: If a patient is currently admitted to that bed, you will not be able to admit another patient. If there isn't a patient in that bed, then whoever was admitted to that bed previously was not discharged. Use the report "Current Inpatient Listing" and see who is still admitted to that bed.

2. **Question:** We use bed 2A for both adults (North Ward) and pediatric patients (South Ward). How do I assign this bed to the 2 wards in PIMS?

   Answer: In the SAF (Set up ADT files) option, use the Room-Bed setup option. Add your bed to the list and then add the 2 wards. Remember, to add another ward, move your cursor to the blank line under NORTH, and then type in SOUTH or whatever the other ward is.



3. **Question:** Can a patient be on the Seriously Ill or DNR list if they are an outpatient?

Answer: No, Seriously Ill is a designation for inpatients only. Both the SI and DNR designations are automatically deleted upon discharge. Once discharged, a patient is considered an outpatient.

4. **Question:** My staff has noticed that there are duplicate Incomplete Chart entries for a patient. How do we fix this?

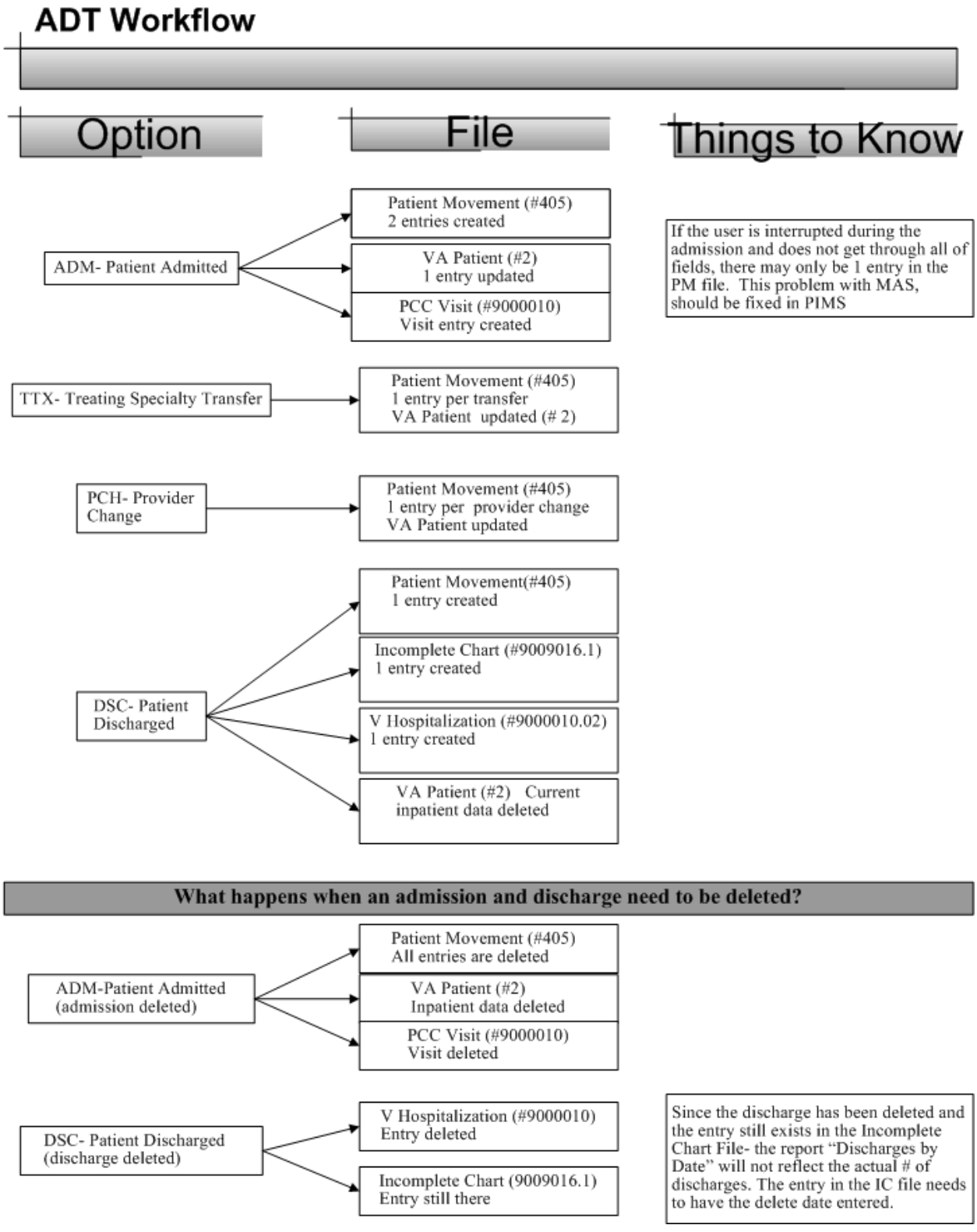
   Answer: To delete a bad entry in Incomplete Chart, select the entry, then go to page 2. At the bottom, you enter in a DELETE DATE. This date is used ONLY to delete bad entries in ICE.

5. **Question:** One of the staff is trying to edit a patient's incomplete chart information and it is giving them a weird message: `THE FORM COULD NOT BE INVOKED`.

   Answer: Any user can fix this themselves. Follow these directions:

   Sign into RPMS and type **TBOX** (for Tool Box) and then **ED** for Edit User Characteristics. The first question is TERMINAL TYPE. Change it to C-VT100. That's it.

12.0 Appendix B: ADT Workflow



13.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the ITSC Service Center by:

Phone: (505) 248-4371 or
(888) 830-7280

Fax: (505) 248-4363

Web: http://www.rpms.ihs.gov/TechSupp.asp

Email: ITSCHelp@mail.ihs.gov